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► To cite this version:

Philippe Le Moigne. Neither healthy nor sick: Psychiatric standards of deviance and conformity. 2009. halshs-00351670

HAL Id: halshs-00351670

<https://shs.hal.science/halshs-00351670>

Submitted on 9 Jan 2009

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Neither healthy nor sick *Psychiatric standards of deviance and conformity*

Abstract

The article examines the tensions involved in the development of treatment for mental disorders during the period 1950-1980 in the United States. It relates those tensions to the diffusion of a social ideal strongly influenced by the subjectivist fervor characteristic of post-war America but also internally contradictory. Psychiatric diagnosis came to be seen as a way of disqualifying the individual, and this line of criticism went so far as to question the very existence of mental illness. But this context also worked to identify psychic disorder with an incomplete self, so that mental health came to be understood as a kind of generic measure of individuality. The article first considers the antagonism between these representations as suggested by the effects they had on professionalization and the division of labor in the psychiatric field. It then seeks to show how the set of nosographic standards that were established at the end of the period—the famous DSM-III—offered a means of negotiating and reconciling the different visions of mental disorder, by separating both health and pathology out from questions of social normality.

Introduction

Sociology of health has been more interested in studying the effects of medicine than accounting for the expectations that led to its extraordinary rise after 1950. Parsons (1951), for example, analyzed the integrative function of treatment as a response to the danger of marginalization induced by disease. And in a critique often made of psychiatry (Conrad 1992), sociologists claimed that medical practice was a powerful relay in diffusing stereotypes and social domination (Goffman 1961, Goffman 1963, Scheff 1966, Castel 1981). What is clear from many of these studies is that medicine's function after World War II is understood

as one of integration or control (Conrad and Schneider 1980), a function external to its direct concerns, though what purposes were driving its own development are not explained. The expansion of psychiatric treatment after 1950 in the United States, and the concomitant protest movement against it, which lasted until the late 1970s, suggest a different angle from which to consider medicalization. The expansion of concern about health seems first and foremost to echo the particularly subjectivist tone of post-war America. In this context, the issues of subjectivity and health seem to have become intertwined. Their relation may be described thus:

- 1) *Self-determination and conforming to the self.* American subjectivism accepted the idea that the individual can conceive thoughts, actions, and aims specific to him or her (Baumeister 1987, Danziger 1997). This perspective goes beyond the individualism that structures conceptions of citizenship and free trade. In those conceptions, the individual is understood to act to his own advantage but he can only choose the most profitable option from within the set of constraints and benefits presented by the given situation. Contemporary subjectivism is more radical, understanding relation-to-self to be sufficient to determine what is most advantageous. Here the idea is that the individual need only choose from among the options available to her the one that most directly bolsters her singularity (Martin 1981). This perspective condemns negation of the individual and encourages personal distinction. Here the individual is not merely watching over his own interest, determined consciously, but is also learning to show interest in himself as an object worthy of esteem (Mruk 1995). Self-realization and conformity to the self thus came to serve not only as a principle for explaining behavior, but also as a moral obligation, with the result that each person is required to work toward his or her own self-fulfillment (Cushman 1995).
- 2) *Mental health as condition and measure of individuality.* The defense of individuality favored the expansion of psychiatric treatment as much as it worked against it. What is a “sick self”? With regard to insanity in particular, the idea that the self could be sick was taken as a contradiction in terms: either the individual is in control of her acts, in which case the diagnosis of mental disease seems to involve an arbitrary social discrimination; or she is no longer capable of self-determination, in which case the disease has annihilated her selfhood. But defense of the self also fueled recognition of mental disorder by helping to redefine it. The incomplete self, or insufficient self-

esteem, was identified as a full-fledged source of distress, even morbidity, that required medical or psychotherapeutic treatment. With this connection established, mental health was conceived not only as the indispensable condition for personal self-affirmation but also seemed to represent a means of measuring the degree to which it had been realized.

Between 1960 and 1980, these decidedly antagonistic views twice worked to regularize the status of mental illness. First, the mentally ill person's incapacity was relativized in such a way that psychic affection came to seem less aberrant. Later, and symmetrically, psychic disorders acquired the status of a risk or vulnerability likely to affect any and all individuals. But this process rapidly ran up against a series of impossibilities. How could pathology be distinguished from being bewildered and distraught; i.e., two of the most ordinary social emotions? How could treatment expansion be contained within reasonable bounds without undermining the aspiration to well-being?

The present two-part study seeks to explain how these questions were handled. The first part presents a synthesis based on my comprehensive reading of socio-historical studies of psychiatry in post-war America—the first part of the research. The substantial number of such studies done in the last ten years allows us to form a more exact picture of medicalization in this sector. Most importantly, the studies underline the paradoxical effect of the social interest elicited by psychopathology. From 1950 to 1980 that movement played its part in the remarkable growth of therapeutic activity, though it did so primarily outside of and against psychiatric treatment (Abott 1988). What enabled psychiatry to reconquer influence in the early 1980s was the set of nosographic standards it developed, the famous *Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III)*. This historical material provides a frame for the second part of the research, presented in the second part of the article: an analysis of the five-axis structure of the *DSM-III* and of decisive stages in its construction. The analysis makes it possible to show that psychiatry regained authority in large part due to the negotiation and reconciliation role it played at this juncture. Specifically, the standards offered a means of separating out both health and pathology from social normality. This in turn permitted psychiatric diagnosis to become associated with a less contradictory defense of the individual.

1. Regularizing psychic disorders: professional organization and division of labor in the mental health field, 1950-1980

1.1 *The two faces of disinstitutionalization*

In 1963, the United States Congress passed the “disinstitutionalization” law (Grob 1983, Grob 1991, Shorter 1997, Menninger and Nemiah 2000), thereby putting an end to construction of mental asylums and limited the vocation of public psychiatric hospitals to treatment of chronic disease. The creation of Community Mental Health Centers (CMHCs) under the jurisdiction of the states was an attempt to counterbalance the effects of this policy by facilitating treatment of the mentally ill persons in open structures and promoting their social integration. The effects of the legislation were considerable: from 1955 to 1988, the number of patients admitted to psychiatric hospitals plummeted by nearly 80% while the annual volume of treated cases increased fivefold (Shorter 1997). This development reflects the growth of the private hospitalization sector and the rise of local treatment arrangements. But the extensive development of treatment, particularly of community structures, primarily benefited persons with only slight pathologies. For the vast majority of destitute psychotic patients, disinstitutionalization meant being deprived of care. The chronic overcrowding of public hospitals and the invention of psychotropic drugs were major forces behind the policy decision to curtail use of state asylums. But that policy also echoed the demands of former patients and the civil rights movement, all generally associated with 1960s anti-psychiatry.

The asylum approach had rejected the notion of the patient’s free will; it was therefore compatible with the recommendation that the patient be removed from society. According to the *parens patriae* doctrine, confinement guaranteed protection of both society *and* the patient, and it was up to the state to ensure that the patient received appropriate treatment. In 1975 it was determined that a patient who had committed an offense fell under police and judicial jurisdiction. As someone endowed with will, he was now subject to trial.¹ Paradoxically if indirectly, patient advocacy movements worked in favor of this change. They had first developed as self-help groups in the early twentieth century under the mental hygiene banner. The first struggle of patients and former patients had been against institutional mistreatment. In the 1960s they extended their demands to the area of citizenship, working to have the patient recognized as a subject endowed with legal rights. In the struggle against abusive confinement and shock therapy, these movements obtained a clause requiring

that patients be consulted and that they consent to the hospitalization decision as well as to type of treatment. In 1977 they demanded that patients be allowed to participate in evaluating the effects of the disinstitutionalization policy, alongside the National Institute of Mental Health (NIMH). This joint evaluation was at the origin of the 1986 legislation entitled Protection and Advocacy for Mentally Ill Individuals Act.²

In the 1980s there was much dissent within the anti-psychiatry movement. For the most radical, who were in line here with the “consumer survivor movement,” mental illness did not exist. They rejected pharmaceutical therapies and contested the legitimacy of the psychiatric profession. This part of the movement opted to promote alternative care organized outside the medical system. Lacking resources, it ran out of steam in the 1990s. In striking contrast to the anti-psychiatry movement, other organizations were able to develop just as radical a critique of psychiatry in the name of mental illness. The post-war context offered new legitimacy to environmental approaches to psychic affection. The substantial increase in what Kardiner called “the traumatic neuroses of war” among soldiers seemed to corroborate the mental hygiene theses that had been developed in response to the Great Depression. In this understanding, any individual confronted with intense life events is susceptible to developing a mental affection (Pols 2001, Barke et al. 2000, Young 1995). This viewpoint requires conceiving of psychic disorder in terms of shared vulnerability and seems to suggest the relevance of vastly enlarging the scope of health policy. Moreover, the mental hygiene contingent was pleading for use of prophylactic action, claiming that “healthy” subjects needed preventive treatment for the traumatism they were likely to undergo upon contact with social life. In this sense, the movement envisioned confinement to an asylum as an artificial means of protecting patients against the life conditions that were at the source of their disorder; it therefore favored an *in situ* treatment policy.

These demands, made either to defend patients directly or prevent the development of pathology, generally went together with approval of disinstitutionalization. But in the first case, the patient’s right to autonomy required explicit rejection of any idea of disorder or medicalization, with the risk of reducing treatment to the barest minimum. In the second, the notion of mental illness seemed on the contrary to work as a lever for achieving recognition of the individual’s vulnerability and a right to protection against the aggressions of social life, with the related risk of a particularly inflated and inflationist mental health policy.³ This was the drawback of legally conferring the role of expert on users of treatment arrangements and

structures. Curative action as practiced in the area of mental health now concerned the patient's personal feelings and thus created an entirely new kind of user demand and knowledge. This in turn worked against the monopoly logic by which any activity sector becomes professionalized (Abott, 1988). Therapeutic action broadened the spectrum of psychic complaint to include the entire domaine of ill-being, while making reception and eligibility of that complaint more complex. Diagnosis of it could no longer be left up to the therapist alone, as it had been, nor delegated entirely to the competence of the individual.

1.2 *Apogee and decline of clinical psychiatry*

During the 1930s, psychiatry enjoyed solid standing within medical science due to its alliance with neurology. This association enabled it to hold its own against the liberal practice then developing in the United States outside the profession, practice strongly influenced by psychoanalysis. Psychiatric research, which was receiving neither state nor foundation funding, remained entirely embryonic. The profession's institutional standing, forged by medical schools and hospital practice, was compatible with approach diversity but was nonetheless dominated by psychobiology and shock therapies (insulin therapy, electroshock therapy, etc.). After the war, public receptiveness to the theme of mental health gave rise to a new demand: psychiatric treatment centered around psychotherapy.⁴

The NIMH, founded in 1946, used the better part of its financial resources through the mid-60s to train new practitioners to meet this demand. Above and beyond the Ph.D. in medicine required by the psychiatric profession, the policy promoted a training approach strongly marked by psychoanalysis.⁵ Psychic health was then an integral part of treatment in general hospitals as well—this was the apogee of clinical work. “Liaison psychiatry”, invented during the 1930s, was on the rise. In addition to the goal of reducing disease, this approach aimed to orient hospital treatment toward treatment of the person as a whole (Laurence and Weisz 1998). Psychiatrists were called upon to train physicians in relational techniques. They set up interface services in hospitals to ensure that patients were listened to before being operated on, that they were followed up on, and that any psychopathology was detected. But the central role thus granted to clinical psychiatry could not resist against opposition from the medical corps. To preserve their position, doctors denounced the negative influence that the psychotherapeutic approach was likely to have on patient health because of the *rapprochement* it suggested between hospital and asylum. Meanwhile, psychotherapy

sharpened divisions among psychiatrists by giving priority to the individual over the pathology.

The critique of the psychiatric institution, intensified by sociologists at the turn of the 1960s, had a devastating effect on the profession, especially since much of the criticism came from clinicians themselves. The debates roiling the profession at the time included the question of how to characterize mental affection. On one hand there were the arguments that denied psychic disorders the status of illness, preferring to represent them in terms of disturbed personal development. Some of these perspectives had in common the idea that the origin of dysfunction is social, and on this basis denounced the pathogenic role of institutions or the market economy (Laing 1965, Horney 1950, Crossley 1998). Other lines of argument included a refusal to attribute the status of affection to development disorders. Some clinicians, following Eysenck in his opposition to psychoanalysis, claimed that many neuroses partook of a “pathology of existence”; i.e., they amounted to normal conduct which there was no cause to treat (Eysenck 1975). This understanding, frequent among psychiatrists convinced of the biological etiology of mental disorders, went together with opposition to what was considered excessive psychiatric intervention in social life. But it can also be deduced from opposition to the idea that mental illness exists. Characterizing behavior in pathological terms was also seen as a way of exonerating the individual, allowing him not to face his responsibilities or obligations (Szasz 1964). In this sense the point was not merely to denounce arbitrary medicalization but also to critique the excessive legitimacy that the complaint of ill-being seemed to have acquired.

This question was in part dealt with through the new community treatment structures. Through the need they created for massive recruitment of psychologists and social workers, these structures worked to demedicalize treatment and consequently to diminish psychiatric authority.⁶ This recomposition of the professional structure was facilitated by the legislative void in the United States around the practice of psychotherapy. Despite demands from psychiatrists and psychologists, no official title or training requirements have ever constrained psychotherapeutic practice there (Buchanan 2003). The decline of the profession was further accentuated in the early 1970s with the development of health insurance and the introduction of psychotropic drugs: a major percentage of treatment once given by mental health professionals was now being given by general practitioners. This way of handling the problem attests directly to the remedicalization movement, which was beginning to gain the upper

hand in characterization and treatment of mental affection. This process was not necessarily favorable to expansion of psychiatric practice since it worked first and foremost to substantiate the general medicine supply source,⁷ but it actually turned out to be decisive in reestablishing the authority of the discipline. For with the development of therapeutic drugs, psychiatry could move into science, and accede to research funding, at the intersection of biology of the brain and psychopharmacology (Healy 1997). Moreover, the substantial increase in number of persons treated enabled psychiatry to claim the expert position. In response to the diffusion of wishes and expectations relative to psychiatric treatment, the profession was soon called upon to guarantee both patients and practitioners reimbursement for drugs and therapy sessions (Barton 1987). The fact is that public policy, which in the 1960s set about managing the explosion in treatment user and market sector demand, favored a specifically medical approach (Marks 1997), and this in turn functioned as an endorsement of psychiatry's claims to a monopoly in the area of diagnosis.

1.3 Administrative and market third parties

In the absence of universal public health insurance in the United States, the matter of reimbursement was subject on the one hand to the power games of private insurance companies, on the other to the sharing out of administrative responsibility for welfare aid between the federal and local echelons. In the late 1940s, the private health insurance market was booming due to a tax incentive policy encouraging employer participation and consequently reducing contract costs for individuals. This expansion did not benefit psychiatry since the insurance companies at first intended to cover only duly qualified pathologies for which drug therapy was available. Overcautiousness in the market sector, reduced hospital supply, and treatment decentralization thus worked to favor the development of a highly differentiated treatment payment system: payment for psychotherapy was in large degree left to private initiative, whereas treatment for the most chronic psychic affections continued to be publicly funded but in a way that was both more costly and more selective than before. The scarcity of state structures and the fact that hospital costs were only reimbursed if the patient had private insurance coverage reduced poor people's access to treatment. Meanwhile, the public Medicare and Medicaid welfare programs, created in 1966 to cover the health needs of the elderly and the poor respectively, were not successful either in making treatment more widely available or reducing spending. At the end of the 1970s, the state was covering more than 40% of all mental health treatment costs.⁸

In 1980, in response to growing mental health expenses, the federal government moved to increase the cost to users of seeking treatment, either by requiring increased participation from employers or requiring users to take out complementary coverage. Moreover, hospital funding in this area was from then on organized not on the basis of projected budget costs but reimbursement for treatment. In 1983, budget allocation was indexed on Diagnosis-Related Groups (DRGs), a criteriology developed on the basis of a national sample of the hospitalized population. The system was made up of 500 clinical groups; for each group a standard length of hospital stay and intervention level was calculated (Menninger and Nemiah 2000). Budget logic that implies breaking down treatment into its various components may be valid for surgery, but it only imperfectly applies to the set of dimensions involved in psychiatric treatment. Likewise Medicare gave first priority to somatic pathologies; mental health only figured among treatments for neurological affections, first and foremost Alzheimer's disease. In 1987, this restriction was dropped and treatment for psychic disorders began to be covered at the going pathology rate of 80% (of a pre-set annual expenses ceiling). Under the term Medical Management, Medicare was now applying a restrictive definition of medical practice that limited it to the acts of prescribing, pursuing, and modifying therapeutic arrangements. The program thus aimed above all at prescription drug management. While that principle did not exclude psychotherapy, the reimbursement rate for it was only 50%.

The American policy approach to mental illness attests to the federal administration's intention to have the society pay part of the costs of psychiatric treatment, in the same way as it set limits on the expansion of personal insurance through a series of arbitrated decisions. With cost rationalization we have the introduction of administrative standardization, a standardized decision-making procedure using accounting logic. By then general recognition of mental illness had subjected the psychiatric profession to a set of rival expert opinions: personal, professional, disciplinary, etc. Now bureaucratic regulation aggravated this status drop while facilitating affirmation of a new body of expertise within the discipline; namely, symptomatology and therapy evaluation. The principle of rationally managing reimbursement for mental health treatment implied a standardized nomenclature of disorders (Berg, 1997).⁹ Meanwhile, in the field of biological and pharmacological experimentation there was demand for comparable inclusion criteria, and therefore also for diagnosis standardization. Standardization thus ultimately amounted to regulations for evaluation, and constituted a

space that lent itself well to resolution of the conflicts created by the problem of how to designate mental disorders. Standardization worked to institutionalize a new frame of reference and action, one capable of guiding and unifying the new policy orientation of the American Psychiatric Association and the strategies of minority representatives and patient associations. This is one way of understanding the enormous success of the *Diagnostic and Statistical Manual of Mental Disorders-Third Edition*, published in 1980 (APA 1980).

2. Health, between treatment and well-being: the structure of the DSM-III

DSM-III categories are meant to be both impersonal and generalizable; in this respect they are perfectly, and deliberately, consistent with bureaucratic universalism. Through its scientific orientation, the manual also claims to represent an instrument of independent, neutral judgment, and to have resolved through proof the tensions generated by the task of discriminating among mental disorders. This is an excessive claim. No classification can be natural; that is, the equivalent of the real (Bowker 1999). All classifications are founded on an architecture; i.e., a interpretive hypothesis or at very least an anticipation of reality. A sufficiently explicit hypothesis or anticipation can be compared to the facts and possibly recognized as likely, plausible. A remarkable feature of the DSM-III is that the architectural elements were not fit together through a unified interpretation of pathology; the manual is overtly atheoretical.¹⁰ Still, the nomenclature is informed by a logical structure. And though that structure was not made explicit by the manual, it did introduce a series of new distinctions. To understand their meaning, it is useful to consider the conflicts generated—and resolved—by the work of determining these standards. The way homosexuality was delisted is particularly exemplary of how the psychiatric paradigm was being restructured.

2.1 Delisting homosexuality: prefiguration of a model

Sharp tensions punctuated the drafting of the Manual, particularly because its designers had rallied to a categorialist, endogenous vision of mental affection (Blashfield 1984). In contrast to dimensionalism, a view supported by psychologists where the assumption is that psychopathology is diffused through the population as a whole to varying degrees, the assumption of categorialism is that psychic disorders involve traits that are discrete entities common to certain individuals only. From this perspective, the standardizers of psychiatric

diagnosis had to consider three points: whether the traits listed did indeed define an atypical phenomenon; if that specificity manifested itself through a difficulty or deficiency; and if it actually attested to a psychic affection.

The conflict that developed between the American Psychiatric Association and representatives of gay movements in the early 1970s brings to light the terms in which it proved possible to negotiate this issue. In the DSM-II, published in 1968, homosexuality had been listed as a sexual orientation disturbance and therefore classified as a mental pathology. During the 1970 APA Convention, a number of activists, first among them members of what is now the Association of Gay and Lesbian Psychiatrists, contested this determination, claiming that homosexuality represented a normal variant of sexuality. Psychoanalysts, who were in the majority in the APA, were against delisting homosexuality. To resolve the crisis, Robert Spitzer, chief editor of the Manual, argued as follows: accepting the arguments of the gay movement, he noted that scientific data did not allow for identifying homosexual behavior as a biological dysfunction; above all—and here he cited the activists' experience—being homosexual was not an obstacle to well-being (Bayer 1981, Kirk and Kutchins 1992). Spitzer's idea was to plead in favor of delisting homosexuality while maintaining the possibility that it could represent a source of suffering. He proposed creating a new diagnosis, "ego-dystonic homosexuality," and reserving application of it to subjects who were uncomfortable with their identity. This proposal was unanimously accepted by the APA Administrative Board in 1973.¹¹

The way this conflict was handled and resolved is exemplary in that it managed to integrate the entire set of dimensions understood by the profession to be health-related: 1) it gave a foothold to social legitimization of homosexual identity by recognizing it as a full-fledged expression of individual autonomy; in this sense, psychiatry was acknowledging that its diagnosis should not produce a stigma that could undermine a legitimate claim to well-being; 2) though the way the conflict was handled reflected acceptance of the idea that the subject's full and positive development could constitute a health criterion, ill-being was not recognized as a pathology criterion. The idea in the Manual is that case studies would allow for understanding how homosexual identity may give rise to psychic suffering and therefore appropriately lead to treatment, particularly psychotherapeutic treatment. However, such expressions of distress also legitimated the decision to abandon categorization of homosexuality as a pathology: first, their singularity forbade all generalization; second, the

Manual purported to relate mental affection to physiological incapacity, and the dissonance or lack of self-fulfillment expressed by individuals seeking psychiatric therapy could not be confused with any such incapacity.

This *modus vivendi* attests not only to the possibility of sporadic alliances between physiologist and subjectivist orientations but governs the structure of the DSM-III as a whole. Constructed on the basis of just this play of constraints, the Manual bears the mark of a negotiated order, just as it worked, by its diffusion, to institutionalize that order. The most immediate effect of this labor of composition was to generate the notion of mental affection as *relative* incapacity.

2.2 Neither healthy nor sick: deviance and conformity according to the DSM-III

The architecture of the DSM-III is “multiaxial,” made up of five independent listings. According to the system’s designer, Theodore Millon, the sum of a patient’s ratings for the five listings should allow for making a general assessment (Millon 1983).

- 1) Axis 1 (*Clinical syndromes*) lists psychiatric disorders (schizophrenia, emotional disorders, anxieties, drug addictions, etc.) and gives a diagnostic grid for each. The notion of syndrome encompasses the idea that a pathology is constituted when a disturbance in expression (behavioral, mental, or emotional) can be paired with a physiological dysfunction itself discrete, or suggests the presence of such a dysfunction. 2) Axis 2 (*Mental retardation and personality disorders*) lists psychopathologies or deviant conduct that are not considered morbid in the medical sense.¹² 3) Axis 3 (*Relevant physical disorders*) lists somatic affections and is aimed first and foremost at producing a differential diagnosis; i.e., determining whether the patient’s behavior is due first and foremost to an organic illness. 4) Axis 4 (*Psychosocial stressors*) lists environmental factors that might induce stress and suffering in the patient. The objective here is to evaluate to what degree patient’s living circumstances aggravate his pathological state or, on the contrary, may work to improve it. 5) Axis 5 (*Level of adaptive functioning*) is designed to measure what degree of patient rehabilitation or integration may be expected during treatment or at the end of it.

The axiology of DSM-III represents a break from psychoanalysis. In DSM-II, the breakdown of affections into neuroses and psychoses was motivated by degree of severity or by degree to which patient's perceptions was congruent with reality. The differentiation principle affirmed in DSM-III recognized pathology as signaling an objective capacity deficit regardless of the disorder under consideration. In this sense, the dysfunction that manifests the mental disorder and is motivated by it can in all probability be established independently of the circumstances or representations in connection with which it came into being (Blashfield 1984). However, in contrast to a classic psychobiological reading of psychopathology, the Manual designers also accepted the idea that the endogenous economy of the psychic disorder did not affect the person as a whole. In other words, the nomenclature recognized the patient as an individual capable of determining his or her own behavior independently of the disease. Patient's autonomy was in all probability only partially abolished by the disorder:

“A common misconception is that a classification of mental disorders classifies individuals, when actually what are being classified are disorders that individuals have. For this reason, the text of DSM-III avoids the use of such phrases as ‘a schizophrenic’ or ‘an alcoholic’, and instead uses the more accurate, but admittedly more wordy ‘an individual with Schizophrenia’ or ‘an individual with Alcohol Dependence’” (APA 1980: 6).

By logical extension, this perspective accepted the idea of pathology as a kind of damage of which the patient is not guilty, but did not for all that clear her of any responsibilities. The individual is the carrier of his illness, the occasion for it, but can still answer for his actions, as can the drug addict or pedophile. The attribution of pathology does not stand as moral exoneration or a substitution for identity: though on the one hand the illness does not deprive the individual entirely of her autonomy, on the other her irresponsibility remains partial.

Axis 2, personality disorders, explicitly reflects this understanding, presenting a map of traits likely to be common to all individuals and that allows for determining to what degree the patient's idiosyncrasy—in relation to this distribution—conforms to or deviates from the average. The deviations listed here are not established with reference to pathology but to the norm; more exactly, they are deviations compared to behavior that according to the Manual may reasonably be expected of an individual in society.¹³ Pathological personalities such as

the “antisocial” or “dependent” individual may be given a type of therapy motivated by the expectation that it will correct their behavior.¹⁴ But by virtue of axis independence, the DSM-III suggests that these personalities, though deviant, are no less healthy than others when considered in relation to characterized mental disorders. Inversely, this axiom allows for thinking that the individual affected by a psychic disorder is not necessarily deviant. Moreover, given that the patient is the carrier of his or her illness, the social context is not understood to induce mental morbidity. Under the term “endogeny,” the DSM-III makes determining mental disorder depend on individual physiology. This clause reflects an understanding of psychopathology wherein the social relation is conceived in terms of an ecology; that is, a context connected neither to the illness nor, earlier on, to the individual himself or herself.

“On the notion of syndrome the Manual specifies: “In addition, there is an inference that this is a behavioral, psychological, or biological dysfunction, and that the disturbance is not only in the relationship between the individual and society. When the disturbance is limited to a conflict between an individual and society, this may represent social deviance, which may or may not be commendable, but is not by itself a mental disorder” (APA 1980: 6).

The manual thus clearly recognizes that the subject may undergo pressure from the milieu in which he lives, or fall victim of a stressful situation. Axis 4 allows for this possibility as well as the suffering that may accompany it. Once again, however, this distress is not identified as a pathology.

2.3 Suffering, stress, vulnerability: the dark side of normality

The distinction introduced by Axis 4 of DSM-III between suffering and psychic disorder takes into account the ill-being that may be generated by the condition of mental illness, and in this sense it echoes patient movement demands. But it also indicates that while this distress is often associated with the illness and may constitute a corollary to and even a harbinger of it, it should not be taken for a symptom, but rather occurs *in addition* to the illness.¹⁵

“In DSM-III each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is

typically associated with either a painful symptom (distress) or impairment in one or more important areas of functioning (disability)” (APA 1980: 6).

This explains why characterizing the depression syndrome was so crucial in constructing the nomenclature (Ehrenberg 1998). Admitting depression as a distinct entity meant that it was possible to formally distinguish the depressive person’s pathological sadness from the distress experienced in mental pathology and also from the distress that everyone experiences due to the ordinary vicissitudes of human existence. The depression entity allowed for establishing suffering as a symptom, but it also designated the point beyond which this conjecture could not go. Depression could not be qualified beyond detailed observation of the patient and signs clearly indicating an episode (mood disturbance, psychomotor slowing, self-devaluation). Psychiatry was here affirming its expertise by applying a limit to diagnostic legitimation of ill-being. But it was also suggesting that the kind of depression that was qualified as “normal” in psychopathology was akin to an ordinary condition rather than a constituted affection, and thus that suffering and normality could go together (Marsella et al. 1987).

Like the mental hygiene argument, this view contained an admission of fragility. It reduced by just that much the benefits to be expected from integration: conformity did not protect the subject from ill-being, or even from mental disorder, because the social context had no hold over the illness. Since personality troubles did not designate a mental pathology, deviance itself was relativized. The Manual’s disjunction of illness from transgression worked to reintroduce both into the body of sociality, alongside conformity, where they represented less an internal break than a continuum of mental states. In contrast to the pathology designation, normality included the possibility of full autonomy but also that of deviance and suffering. And it was the underside of the capacities conferred on persons, and of the performance ethic that generates the principle of those capacities: the healthy individual can exercise authority but cannot exonerated from responsibility for his or her acts or protected from possible suffering. In contrast to the view opened up by Freudian psychopathology in its time, the individual’s weaknesses and faults are no more what found the purpose of therapy than is catharsis its goal. As underlined by the expression chosen by contemporary psychiatry, the purpose of therapy is first and foremost “an improvement.” In this context, the value of treatment is above all to repair: it works to correct a neurological, behavioral, or cognitive

dysfunction, and there is no claim to produce dividends beyond that. Still, with Axis 5 the Manual also recognized a more positive definition of health. What is that definition?

2.4 Social functioning and well-being: personal development as health ideal

Axis 5 evaluates patient's degree of integration or rehabilitation in the course of therapy or afterward. Impaired functioning includes patient being dangerous for himself or others—deviance is thus forefronted here. Average, i.e., partially impaired, functioning refers to situations where patient's symptoms have a detrimental effect on communication with others: the impact of the pathology in terms of individual performance. Lastly, acceptable or satisfactory functioning corresponds to absence of symptoms, patient's interest in work and leisure activities, and some enduring social relations: functioning is called normal when it is characterized by an asymptomatic state *and* integrated behavior.

The notion of functioning introduces a certain correspondence between social integration and personal fulfillment. Most importantly, this correspondence signifies that improvement due to therapy is likely to improve patient's social relations. It likewise underscores that effectively realized rehabilitation can bring about remission. Second, with the suggestion that personal fulfillment presupposes integration, it lays down a hierarchical principle. This is why deviance is deemed to work against well-being even more directly than pathology does. But the gradation here also applies to the improvement produced by therapy. Though patient remission favors integration, it does not necessarily lead to well-being. By extension, this principle tends to suggest that patient's rehabilitation is a condition for his or her positive and fulfilling development but is not sufficient to produce it. This understanding is only possible if another entity, both separate and superior, is acknowledged, under the heading of well-being. Under that condition, conformity can be distinguished from fulfilling personal development, and treatment from a more idealized vision of health.

The disjunction between treatment and health brought about by the theme of well-being had a direct extension in psychiatry through the distinction now made in the discipline between improvement and mental health, or between mental health and positive mental health (Ryan & Deci 2001, Vaillant 2003). By the Axis 5 scale, individual functioning is deemed adequate when the subject, now free of symptoms, is engaged in social life and satisfied with that involvement. But that such functioning is normal does not mean it is optimal. This means

that normality, the normality of acceptable states, is not the sign of perfectly achieved health but rather of a low-threshold well-being. In 1990 for the DSM-IV, the initial Axis 5 gradient, which ranged from 0 to 100, was reduced to a range of 0 to 90. The highest interval was eliminated because it seemed to apply to subjects demonstrating positive mental health, those who functioned particularly well in *all* areas (Guelfi 1998). In other words, according to the Manual, optimization of individual potential is *not a matter for* psychiatric treatment, but at the same time it cannot be entirely ignored by the discipline. From a strictly medical perspective, psychiatry intended to permit the patient to reach a positive *enough* condition, compatible with his or her ideals and capacities. Above that threshold, it no longer recognized the patient as a subject susceptible of psychiatric treatment. But from a psychological view, the patient was still accessible to psychotherapy and its set of techniques for treating suffering and enhancing personal development. The quality-of-life or well-being theme thus marks, overall, the need for the clinician to take into account the individual's singularity, and even to promote his or her full self-realization. Once this viewpoint had been linked to treatment, it outlined the contours of a kind of therapy that would be capable of aggregating improvement and personal development, medication and psychotherapy, biological and psychological approaches to psychic disorder, and of bringing together the entire set of mental health professions, despite the structural rivalries among them.

* * *

The impact of this new frame of reference can be measured in various ways. First, it may be observed in the way perceptions of psychic disorders evolved. Phelan and his team, among others, analyzed the development of social representations of mental pathology in the United States by comparing data from a questionnaire distributed first in 1950, then in 1996. They concluded that the social body's receptiveness to psychic disorders had improved: the majority of respondents now identify mental troubles as a risk that could affect them (Phelan et al. 2000). But the impact of the new designations of normality and pathology may perhaps be even better gauged in terms of how patient movement demands have evolved. In 1980 treatment-user organizations, particularly patient family groups, began demanding recognition of the biological character of mental pathology. Marked by a consumerist orientation, these organizations demanded reimbursement for treatment of affections listed in the psychiatric nomenclature, and were opposed to coverage for people with less severe mental health problems, i.e., psychic suffering (Menninger and Nemiah 2000). This movement reflects a

reorganizing of the debate: it now involves not so much a series of oppositions shaped by the imposition of a unique framework as a permanent and continually negotiated intermingling of different representations of health. In this sense, current demands may be said to reflect less an interest in fighting treatment than defending patients' or users' active participation in the treatment process. This process requires psychiatry to respond to increasing demand for labelling pathologies, with the risk of its being perpetually obliged to negotiate its category definitions and the boundaries of its area of intervention.

CONCLUSION

When medicine's relation to social integration or control is analyzed sociologically, the hypothesis of a transference is often cited: medicalization is understood to reflect a process in which moral responsibility has been entirely transferred, term for term, from the community to medicine (Conrad and Schneider 1982). This understanding is informed by a linear vision of social change, however, and does not allow for explaining why treatment has been at the core of this change. If on the other hand we consider the post-World War II demand for health, which gave rise to both increased treatment for mental disorders and critique of such treatment, we are in a better position to grasp the workings of the shift. This approach also requires us to develop a more complex image of medicalization, its context and organization. In fact, what has been at work here are intertwined but partially contradictory processes.

In the United States, the defense of individual autonomy and subjectivity made it possible to recognize the patient as an actor in his or her treatment as early as the 1950s. This recognition relativized the externality of mental disorder, and went so far as to question the very existence of mental illness. But it also worked in favor of a conception of psychic disorder as damage and loss to the person afflicted by it, as well as a risk that could affect any and all members of the collectivity. This reorganization relativized the virtue of conformity, as it was no longer understood to protect one from mental disorder, while acceptance of morbidity risk reduced the normative aspect of illness and its possible identification with deviance. This shift opened the way for the affirmation that illness and ill-being were distinct social categories: the opposition between disease and sociality that had structured mental patient status lost much of its legitimacy.

Defense of the self led naturally to a massive increase in treatment. But it also imported into the field of medicine a problematic that both enriched and complexified the notion of health. Through the issue of well-being, the notion of health no longer concerned mere improvement through therapy but extended to fulfilling development, self-realization. This ideal partially projected health outside the limits of treatment and freed medicine from responsibility for it. But that externality in turn affected medical intervention, by situating in the domain of respect-for-subjectivity a disposition potentially opposed to treatment. The increased demand for health is a means of understanding how contemporary subjectivism both fueled medicalization and constrained how it was organized.

The fact remains, however, that neither the subjectivism that fueled criticism of treatment, nor biologism, the equivalent of subjectivism in the field of psychiatric research, took into account the relational and collective dimension that necessarily impacts upon how a person is shaped. The idea of a “culture-free” self is quite simply unrealistic, just as it is highly unlikely that mental affection will ever be what the organic endogeny hypothesis claims it is, i.e., totally isolated from the social context in which it came to being. If we leave behind both these visions for a more strictly sociological reading of the facts, we cannot fail to see that “well-being” and “fulfilling self-development” do not refer to a state beyond normality; rather they constitute the very epicenter of conformity. Defense of the subject and the health ideal that this defense has given rise to shrink social life down to the life of the individual. The pursuit of personal well-being has come to seem the response to a natural, ontological, or physiological need, whereas it is more exact to say that it reflects individuals’ scrupulous subscribing to the aims designated by contemporary society. In this sense, the demand for health is strikingly paradoxical: despite the way defense of individuality, elevation of autonomy, and interest in personal distinction all seem to focus attention on the individual’s freedom, never have they looked so strongly like moral obligations.

¹. From this date the “guilty but mentally ill” doctrine allowed for adding a measure of treatment to the sentence of a person officially defined as a common criminal (Simon 1992).

². The legislation requires states to ensure the legal defense of patients in cases of abuse or negligence. It also requires that patients be represented on institution administrative boards and participate in

planning mental health programs in the individual states. For persons with a severe disease, the states must enable them to “maintain responsibility, to the greatest extent possible, for setting their own goals, directing their own lives, and acting responsibly as members of the community” (quoted in Menninger and Nemiah 2000: 307).

³. In 1980 the NIMH conducted an epidemiological survey of 20 000 American residents (Robins and Regier 1990). Survey results show 32% of respondents suffering from a mental disorder in the course of their life, and 20% during the year before the survey. These figures reflect extensions to the nomenclature of mental disorders made during the 1970s. The data also reflect changes in ways of experiencing and expressing discontent or failure. It is reasonable to assume that diffusion of psychic complaint was fueled by the fact that dissatisfaction and injustice are today more directly recognized in terms of the impact they have on an individual’s mental or psychomotor vitality. Still, the results raise the question of whether this type of complaint is sufficient to qualify as a mental disorder.

⁴. In 1957, no less than 14% of the American population had received psychotherapeutic treatment (Buchanan 2003).

⁵. At the end of the war, there were 3,634 psychiatrists in the United States, a figure that increased continuously until 1985. By 1962 it stood at 13 000 practitioners; 18,000 in 1965; 25,000 in 1970; and more than 31,000 in 1985. The number then began to fall, and the psychiatry profession found itself in a recruitment crisis (Blashfield 1984). From 1940 to 1965, more than 50% of the psychiatry training curriculum focused on psychoanalysis. Meanwhile the analytic cure was a way of opening the profession up to liberal practice. In the 1940s, the majority of clinicians practiced in hospitals; in 1970, 66% were in private practice (Shorter 1997).

⁶. In 1950, psychiatrists represented nearly 25% of mental health professionals (nurses were over 50%). With the development of outpatient treatment, psychologists and social workers are now in the majority. In 1959 there were 3,000 psychologists in the US; today the estimated number is 250,000, 40,000 working in hospitals or clinics (Capshaw 1999). In 1945 there were approximately 2,000 social workers practicing in the field of mental health; in 1985 they numbered over 80,000 (Shorter 1997).

⁷. It is estimated that since 1980, more than 50% of patients diagnosed as having poor mental health have received treatment from general practitioners. In the US in 1970, the annual prevalence of psychotropic drug prescriptions—80% of which were made by general practitioners—was 10%; today it is over 20%.

⁸. Medicare and Medicaid strengthened the public sector’s obligations toward persons over 65 (or suffering from a physical or mental incapacity) and the poor. The Medicaid program to cover poor people was run by the individual states, and it was left up to the state to decide whether or not to fund psychiatric care for persons under 22 or over 65. The states tended to choose not to pay, meaning that often the only recourse for these populations was federally funded public hospitals, which, as

explained, had been being managed since 1963 in accordance with the policy for reducing receiving capacity (Menninger and Nemiah 2000).

⁹. The instrumentation developed enabled the profession to impose an alternative to the DRG hospital cost assessment system. Since 1982, psychiatric hospital funding has been determined with reference to the Tax Equity and Fiscal Responsibility Act (TEFRA). In this framework, the DRG system no longer applies; diagnostic evaluation is now done with reference to the psychiatric nomenclature.

¹⁰. With the exception of components based on biological and pharmacological research, the manual's demonstration of objectivity is deduced primarily from consensus metrology: it relies on interjudge agreement. The point was to assess convergence of clinical opinion in patient diagnosis, and the demonstrative undertaking was guided by the intention to overcome clinician idiosyncrasy. In this sense it was itself directly marked by the rise of subjectivism: the aim of overcoming the subjectivity and idiosyncrasy attributed to the individual (in this case, each clinician) became so strongly structuring that obtaining consensus was taken for the equivalent of proving (Sadler and al. 1994, Kirk and Kutchins 1992).

¹¹. In similar manner, feminist movements got the "self-defeating personality" disorder, inspired by the psychoanalytic reading of masochism, removed from the manual. The nosography had seemed to suggest that this disorder was more prevalent among women (Valenstein 2000).

¹². With the exception of "developmental disorders" such as autism and hyperactivity, which are included on this axis. The Manual allows itself a degree of ambiguity on this point: the term encompasses affections that are either discrete or likely to appear in childhood.

¹³. The DSM-IV, which followed the DSM-III-R, could hardly be more explicit: personality disorders refer to behavioral modes that "deviate markedly from the expectations of the individual's culture" (APA 1994: 633).

¹⁴. Among the 14 disorders listed in this area, the antisocial personality seeks to satisfy exclusively personal interest whereas the dependent personality is dominated by a compulsive quest for others' support (APA 1980).

¹⁵. The distinction made here between morbid and social factors reflects the decline of social psychiatry and the reactional hypothesis (Schulman and Hammer 1988). In the 1970s, psychopathology stopped attributing a causal role to life events; events came to be considered instead as precipitating factors, foreign to the morbid process (Guelfi et al. 1995). For a time at least, Post-Traumatic Stress Disorder (PTSD) stood as the exception to this rule. That syndrome was integrated into the DSM under pressure from the Veterans Administration, which was trying to obtain federal pensions for Vietnam war veterans. PTSD was first conceived as a normal reaction to an abnormal situation. Since 1994 it has been applied to individuals who tend to develop a pathological reaction to events of any kind (Young 1995).

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